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The Commonwealth of Massachusetts

A REPORT of the SENATE COMMITTEE ON POST AUDIT AND OVERSIGHT

Entitled "PAYING FOR HOSPITAL CARE IN MASSACHUSETTS: THE COMPETITION EXPERIMENT"

(pursuant to Section 63 of Chapter 3 of the General Laws as most recently amended by Chapter 557 of the Acts of 1986)

May 1992
The Commonwealth of Massachusetts

MASSACHUSETTS SENATE
The Honorable William F. Bulger
President of the Senate

PAYING FOR HOSPITAL CARE
IN MASSACHUSETTS:
THE COMPETITION EXPERIMENT
(Senate 1500)

A REPORT
of the
SENATE COMMITTEE ON
POST AUDIT AND OVERSIGHT
Sen. Thomas C. Norton, Chairman
Sen. W. Paul White, Vice-Chairman
   Sen. Linda J. Melconian
   Sen. Robert A. Havern
   Senator Robert D. Wetmore
   Senator Christopher M. Lane
   Senator Matthew J. Amorello

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May 1992
Dear Mr. O'Neill:

Pursuant to M.G.L. Chapter 3, Section 63 as most recently amended by Chapter 557 of the Acts of 1986, the Senate Committee on Post Audit and Oversight respectfully submits to the full Senate the following report: PAYING FOR HOSPITAL CARE IN MASSACHUSETTS: THE COMPETITION EXPERIMENT.

This report is based on research by the Senate Post Audit and Oversight Bureau. It discusses the importance of the hospital industry to the Massachusetts economy, and reviews reasons why health care costs have increased.

Respectfully filed by the Senate Committee on Post Audit and Oversight:

Senator Thomas C. Norton
Chairman

Senator W. Paul White
Vice-Chairman

Senator Linda J. Melconian

Senator Robert A. Havern

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Edward B. O'Neill
Clerk of the Senate
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May 5, 1991
This report by the Senate Committee on Post Audit and Oversight presents a review of hospital care financing in Massachusetts over the last twenty-five years, discusses the importance of the hospital industry to the Massachusetts economy, and reviews, in general, some reasons why health care costs have increased. The report also comments on competition in the hospital industry and predicts that Chapter 495 of the Acts of 1991, the state’s new hospital payment law, will affect the cost of and access to hospital care in the following ways:

• Efforts to reduce health care costs will continue to overshadow efforts to provide quality care.

• Hospital costs will decline for some hospitals in the near term. This will occur because of the competitive price cutting that will initially be demanded of hospitals by large purchasers of care and because of the general slowdown in the Massachusetts economy.

• In the long term, overall health care costs will increase even though hospital costs will show some decline. Price competition will put pressure on hospitals to provide care on an outpatient rather than on an inpatient basis. However, the increased cost of providing outpatient care will override decreases in the cost of providing inpatient care.

• Underinsured or uninsured people in Massachusetts will have less access to hospital care due to competition. Hospitals will not be able to provide as much care for the uninsured or underinsured because they will be providing discounts to many large purchasers of hospital care.

• Price competition will cause some hospitals to merge into “care systems” which, because of their resulting combined market strength, will not have an Incentive to give discounts to purchasers of care.
• Health insurance coverage for small businesses in Massachusetts will continue to be expensive because small purchasers of care will have to subsidize the discounts given to large purchasers of care. Ultimately, the increasing cost of health insurance for small businesses will force more of them to eliminate this coverage and further increase the number of uninsured residents in Massachusetts.

Although the Committee has performed studies that have included proposed legislation dealing with new issues, review of such a newly enacted statute is somewhat of a departure from established Committee practice of reviewing laws or programs which have been in existence for a period of time. The decision to study this issue — the new way to establish prices for hospital care in this state — was undertaken for one compelling reason: the decidedly experimental nature of Chapter 495, the replacement law. This factor and the sheer magnitude of the dollar cost involved ($8 billion) almost demanded a preliminary review to determine whether there are any unattended oversight or evaluation needs which should be addressed.

The Committee believes the overriding goal of hospital care financing reform in Massachusetts should be to provide access to health insurance coverage for all residents of the state. Because it initiates a public policy that deregulates hospital pricing, the Committee is concerned that Chapter 495 will create a health care system that encourages comprehensive health care benefits for only the wealthy and the beneficiaries of large purchasers of hospital care. The Committee is also concerned that insurers, large purchasers of care, and hospitals could unfairly use market powers to the detriment of small purchasers of care and the underinsured and uninsured. It is difficult to discern how the Massachusetts health care system will show overall cost improvement if discounts are given to some at the expense of others. Consequently, the Committee makes the following recommendations:

1. The consumer protection unit of the Attorney General’s Office should make resources available to monitor consumer protection and anti-trust violations which may occur as a consequence of deregulating how hospitals set prices.
2. Chapter 495 should be amended to include a “fail-safe” system-wide revenue cap. The so-called “90th percentile” charge cap included in Chapter 495 is not fail-safe, is very generous to most hospitals (it doesn’t cap volume growth), and would have a negative effect on payers without market power. Such amendments should require that if system-wide hospital revenues grow beyond reasonable predeter-mined levels, the law is immediately suspended and reviewed.

3. Chapter 495 should be amended to include a two-year sunset provision. Two years after the implementation of the Chapter 495, the Rate Setting Commission should commence a review to determine the effects of hospital price competition.

4. While the Chapter 495 experiment is being tested, the administration should be planning an alternative to this approach should the competitive model fail. Absent firm and decisive national leadership on the issue of health insurance coverage for all citizens, the Commonwealth of Massachusetts should renew its previous effort to provide comprehensive health care coverage for all residents.

The biggest beneficiaries of the Chapter 495 competitive hospital pricing legislation will be the large purchasers of care, large insurance companies, large self-insured companies, and the hospitals from which they purchase their care. Common sense dictates that hospitals that give price discounts to the bulk buyers of care will be forced to make up for these discounts by raising prices for purchasers of care who have no market power.

Access to affordable and relatively comprehensive health care services should be a right for all citizens, not a privilege. Chapter 495 threatens access to affordable health care by allowing prices to be controlled by those who can average market power over hospitals.
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INTRODUCTION

This report by the Senate Committee on Post Audit and Oversight reviews the history of hospital care financing in Massachusetts over the past twenty-five years. The report discusses competition in the hospital marketplace, and comments on the future of hospital care financing in Massachusetts.

The report is divided into four sections. Section one describes the importance of the hospital industry to the Massachusetts economy and describes some principal reasons why health care costs have increased. Section two provides general information on how acute hospital care is paid for. Section three discusses health care competition. Section four presents the report summary and the recommendations of the Committee.

SECTION ONE: THE MASSACHUSETTS HOSPITAL INDUSTRY

The eight billion dollar hospital industry in Massachusetts is prestigious, steeped in clinical tradition, and provides some of the best medical care in the world. It also provides some of the most expensive care. Massachusetts is, has been, and will continue to be one of the most costly places in the nation to receive hospital care.

Hospitals and the Massachusetts Economy

Overall, the hospital industry in Massachusetts is rejecting regional recessionary trends and is prospering. According to the U.S. Labor Department's Bureau of Labor Statistics, the health care service business, which includes hospitals, is one of the strongest industries in the state. Of course, all hospitals are not experiencing this positive trend. In September of 1985, Massachusetts had 115 acute care hospitals. Massachusetts now has 94 acute care hospitals.

Some cynics consider the Massachusetts hospital industry an expensive public works project. However, its supporters argue that the hospital industry in Massachusetts not only contributes to the general health status of the population, it also contributes to the economic health status of the state.

Because hospitals are in the business of giving care and saving lives,

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2 Massachusetts Hospital Association.
there is a tendency not to view them as businesses. However, hospitals
are businesses and contribute to the economy in diverse ways.
Hospitals contribute to the economy by infusing capital. In fiscal year
1990, 101 community hospitals (including teaching hospitals) spent
almost $6.5 billion for total hospital expenses. Almost 57\% of the
expenses, or $3.7 billion, was spent on wages, salaries and benefits
for hospital employees. Hospitals also invest millions
of dollars in capital spending (which provides jobs for the private
sector) and attract millions more in federal and private grants.

Hospitals contribute to the economy by providing employment. In
1990, over 100,000 people were employed by the state's 101
community hospitals (including teaching hospitals). In some regions
of the state, a hospital is the largest local employer. For example, the
Massachusetts General Hospital is Boston's largest private employer,
employing 10,000 full-time employees and 1,700 part-time
employees. In central Massachusetts, the University of Massachu­
setts Medical Center is the largest employer with 4,137 full time and
1,318 part-time employees.

Hospitals also contribute to the economy by improving the health
status of the population. However, it is difficult to measure this type
of contribution objectively. For instance, how does one measure the
value to the economy of disabled employees returning to work faster
because of quality hospital care? How does one measure the value
to the economy of hospital research and development efforts which
eradicate cancers and extend the lives of children and adults who ten
years ago would have died?

Of course, while hospitals contribute to the economy, they also take
from it. It is estimated that in 1992, hospital care will extract at least
$8 billion from the economy. The opponents of further spending for
hospital care feel that $8 billion is more than enough to provide
affordable care to all of the commonwealth's residents. They argue
that high hospital costs have a regressive effect on the economy and
the money spent on these costs could be spent more usefully by
stimulating other segments of the economy. These critics observe that
some of the money spent on hospital care by businesses may be better

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3 Ibid.
4 Ibid.
spent for employee pay raises and company expansion in Massachusetts. They add that some of the money the government spends on hospital care could be better spent on human service programs.

The Cost of Care in Massachusetts

According to the Boston University School of Public Health Access and Affordability Monitoring Project (AAMP), it is estimated that $8 billion will be spent on acute hospital care in Massachusetts in 1992, an increase of $3 billion from 1987 and an increase of over $5 billion from 1981 when spending for acute hospital care in Massachusetts amounted to $2.7 billion. AAMP asserts further that the cost of hospital care in Massachusetts in 1989 was $1.75 billion greater than it would have been had we spent at the national average.

In Massachusetts, the per capita spending on health care averages approximately $3,000 per year, compared to the national average of approximately $2,400. Much of this cost is attributed to the care provided by hospitals, a cost that continues to escalate each year.

Why is it so expensive?

The high cost of health care in Massachusetts has been attributed to many factors. An aging population, an abundance of teaching hospitals, duplicate medical technology, defensive medicine practice patterns, over-utilization of services, and expanded health insurance coverage, have all been blamed for increasing the cost of health care. However, many of these conditions prevail in other parts of the United States and cannot be solely attributed to the high cost of health care delivery in Massachusetts exclusively. The truth is that many conditions have affected the cost of health care over the last twenty-five years.

The problem of high health care costs is not new. Sixty years ago, a study on health care delivery by the Committee on Health Care Costs produced the following finding:

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8 Ibid.
10 A 42 man committee formed in response to the desire of leading physicians, public health personnel, and economists for sound studies on the economic and social aspects of health care. It was supported by $1 million from six foundations.
The problem of providing satisfactory medical service to all the people of the United States at costs which they can afford is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequally distributed...¹¹

Although this quote demonstrates that rising health care costs have been a problem for a long time, their sharp escalation in recent years has caught the attention of the public. Explanations for the health care inflation which has occurred during the last twenty-five years have been sought at all levels of government. While there is room for disagreement on the particulars, the creation of the Medicare and Medicaid programs, the greater accessibility to employer-based health insurance, and, to a lesser extent, the introduction of for-profit health care facilities have contributed to high health care costs. However, simply having the Medicare and Medicaid programs, the availability of employer-based health insurance and the existence of for-profit hospitals does not establish them as the principle causes for high health care costs. Other countries in the world have national programs for the elderly and employer-based health insurance. However, they do not have spiraling health care costs similar to those in the United States.

In the United States, what drives up the cost of care is not the existence of health insurance programs or insurance per se, but the unrestrained use of them by program participants. For example, as employer-based health insurance became more available and more comprehensive, more employees used it. In turn, providers of care took advantage of the reimbursement methods allowed by most health insurers — fee-for-service payment for physicians and cost-based payment for hospitals. Both of these reimbursement methods are inherently inflationary because they encourage utilization of health care services.

During the 1980s, many payers abandoned fee-for-service and cost-based payment methods. The Medicare program has tried to remedy increasing hospital costs by paying hospitals one fee based on the diagnosis of the patient (Diagnosis Related Group) and not for the cost of each service rendered to a patient. A similar program for

physician payments will soon be implemented by Medicare. Some Health Maintenance Organizations (HMOs) have tried to deflate health care costs by contracting with hospitals and paying physicians a capitated rate (capitated payment is when a provider receives a fixed monthly or annual fee for ongoing treatment of an HMO's membership) or a salary for services. Commercial insurers have tried to contain costs through strict utilization management programs. Unfortunately, individual cost containment successes by insurers and payers have led to cost-shifting within the health care system rather than to cost savings to the health care system.

Cost-Shifting

Cost-shifting is a symptom of the disease (rising real health care costs) and takes many forms. One form is when payment shortfalls from government payers and from the free care hospitals had to provide and the bad debt they had to absorb (uncompensated care) are shifted to private payers. Another form is when a hospital gives a large payor or insurer a discount and shifts the cost of the discount to other payers. Another more insidious form of cost-shifting, inter-employer shifting, occurs when one employer insures the care of a dependent who works for another employer.

A study released in October 1991 by the Prospective Payment Assessment Commission, a quasi-governmental organization that studies Medicare payment rates, showed that Medicare paid hospitals only 91% of the amount it cost to care for Medicare patients; Medicaid paid 74% of its real cost of care. However, private payers paid 128% of costs for that group, with the extra 28% amounting to $3.3 million for the average hospital.12

As efforts to curtail cost-shifting by hospitals have become more prevalent, the real cost of health care has continued to rise. These continued increases have caused employers to pass on increasing costs to employees, reduce the level of benefits, or eliminate availability to health insurance altogether. Payers and employers are shifting more of the cost of health insurance to individuals and families in the form of higher deductibles, premiums and co-payments. At the same time, they are strictly managing care and limiting the comprehensiveness of health benefit plans. The results of a 1991 survey by the employee

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benefits consulting firm of A. Foster Higgins & Co. shows that from 1990 rates, employers who require employees to share premium costs for fee-for-service health insurance coverage increased the premium share by 12.9% for single employee plans and 17.4% for family plans. On average, employees contributed 28% of the total family health insurance premium. Deductibles also increased to $500 for family coverage for 32% of the survey participants. Corporate cost-shifting to employees will become more prevalent as company profits are reduced, in part, because of increasing health care costs.

This reactionary type of benefits management ultimately restrains access to primary health care services and fails to recognize that underinsuring or not providing any insurance to employees may cause employees to utilize health care services only when they are extremely ill and/or in an advanced stage of disease. Treating sickness or disease after it has advanced or caused other medical complications dramatically increases health care costs. Over the last decade, even Medicare beneficiaries, many of whom are on fixed incomes, have had to face increasing premiums and deductibles. Elderly Americans now spend more than twice as much on health care as they did before the establishment of the Medicare program when adjusted for inflation.\footnote{Ron Winslow, "Firms Restrain Rate of Growth of Health Costs," \textit{The Wall Street Journal}, 28 January 1992, p. B1.}

Ironically, the expanded access to the health care system sought by the Medicare and Medicaid programs is now being restrained by other payers because of the cost-shifting attributed to the two programs. A recent study by the non-profit group Public Citizen and Harvard University's National Health Program Studies finds that more Americans lack health insurance now (34.7 million) than twenty-five years ago, when the government set up Medicaid and Medicare to pay the medical bills for the poor and elderly.\footnote{Hilary Stout, "Elderly Now Spend Over Twice as Much On Health as They Did Before Medicare," \textit{The Wall Street Journal}, 26 February 1992, p. B6.}

Insidious health care access restrictions are a disturbing trend that, absent fundamental health care reform, will ultimately produce a health care system that provides comprehensive services only to the few who can afford them. Cost-shifting fails to recognize that families and individuals are not the true purchasers of health insurance.\footnote{Jacqueline Frank, "Study: Millions Without Health Insurance," \textit{The Boston Herald}, 19 December 1991, p. 43.}
coverage, and that they have the least leverage in a free market to reduce the cost of care. Cost-shifting causes millions of Americans (those without market power) to be underinsured or uninsured and is a fatal flaw in the present health care delivery system. The problem of cost-shifting will only be solved when useless care is reduced and technological innovation is limited.

SECTION TWO: HOW HOSPITAL CARE IS PAID FOR

Hospital care financing is about money — what it buys, where it comes from, and who pays it out. Money is the fuel that runs hospitals. All the money which is used to pay for hospital and health care services comes from consumers of products and services who are also taxpayers. Businesses and governments do not pay for increased health care costs. If costs increase, businesses pass the costs on to customers and/or employees, and governments raise taxes or reduce money spent on other programs.

For example, most employees and employers share the cost of health care insurance. The employee contributes part of his compensation, and the employer, with revenue received from selling products or services to consumers, contributes part of that revenue. The employer collects the total amount of the premium and pays the insurance company. The insurer then pays the provider of the service with the money received from employers and employees.

The federal and state governments use the revenue they receive from fees or taxes to pay for health care services for their employees and for Medicare and Medicaid patients. The money flows from the consumer or taxpayer through the government to the provider.

Following the money trail shows that health care costs are paid for by consumers and taxpayers, not by the government, insurance companies, or businesses, as is sometimes perceived. Like taxes, health care costs are passed along by businesses to employees and customers in the form of higher health care premiums or higher prices. Charges to governments materialize in the form of higher and/or more taxes or fees (or less services).

The cost of health care in Massachusetts, of which hospital care accounts for over 50% (the highest in the nation)\textsuperscript{16}, is extracted not

only from business and government, but also from the incomes of individuals and families as premiums, co-payments, and deductibles increase. This so-called “hidden sickness tax” costs Massachusetts families an average of $5,321 per year, or $1 out of every $8 in income.\(^\text{17}\)

**HOSPITAL REIMBURSEMENT**

In Massachusetts, as elsewhere, there are five major hospital claims payers: Medicare, Medicaid, Blue Cross, commercial insurers/self-payers and health maintenance organizations (HMOs). Most of these payers act as fiscal intermediaries for consumers of health care. They pay out to hospitals and other health care providers the money they receive in premiums, taxes or fees.

According to information received from the Massachusetts Hospital Association, 86 acute care hospitals reported the following percentages of total charges for inpatient services in fiscal year 1990: Medicare 44.5%, Blue Cross 15.1%, commercial 13.9%, Medicaid 9.6%, HMO 9.1%, self-pay 5.8%, industrial accident 1%, and 1.1% for other.

**Medicare**

Until October 1, 1982, Medicare inadvertently encouraged hospitals to expand and provide additional services. Hospital providers were reimbursed according to the allowed cost of the service. This payment method, known as “cost-based reimbursement,” did not provide any incentives to limit the intensity or the amount of care they provided. For almost two decades, the system fed upon itself. Demand for hospital services, caused by expanded availability of insurance coverage, went up. Hospitals responded to the increased demand by expanding their mix of services and their infrastructures.

After Medicare abandoned cost-based reimbursement, it participated in the Massachusetts all-payer hospital care financing system (Chapter 372) from October 1, 1982, until 1985 when it adopted the Diagnosis Related Group (DRG) prospective payment reimbursement system in Massachusetts. Medicare now reimburses hospitals according to a patient’s diagnosis, not according to the cost of care.

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or the length of the hospital stay. The payment mechanism is prospective; hospitals can estimate ahead of time how much reimbursement they will receive from Medicare by measuring the diagnostic mix of their admissions.

**Medicaid**

Medicaid is a program for the poor and the indigent which covers the costs of many health care services. It is a jointly funded federal/state program (50/50 share in Massachusetts) which became law as part of the Social Security Act of 1965.\(^\text{18}\)

In the 1960s and early 1970s, Medicaid hospital reimbursement was cost-based. However, Massachusetts, in advance of most other large payers, recognized that payments to hospitals had to be restrained. In the mid 1970s, Medicaid changed to a prospective per-diem rate for inpatient hospital services. This prospective payment system was a forerunner of future hospital care financing methodologies.

The per-diem prospective payment plan was premised on the belief that if hospital administrators knew that they had to live within a budget, they could limit spending accordingly. It was the hope of plan designers that hospital administrators would be forced to become more efficient and cost conscious. However, hospitals shifted the financial losses associated with treating Medicaid patients to other claim payers.

**Blue Cross**

Until 1981, the Blue Cross method of reimbursing hospitals, like Medicare and Medicaid, was cost-based. This changed when Blue Cross, the largest indemnity insurer in the state with 2.2 million subscribers\(^\text{19}\), issued a new agreement with the hospitals — the so-called HA-29 contract. This contract was a prospective reimbursement system which rewarded efficient hospitals and was the precursor to the Chapter 372 all-payer hospital payment system.

**Commercial Insurers/Self-payers**

Historically, most of the commercial and self-payer market suffered from cost-shifting by hospitals. Hospitals made up for government

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payment shortfalls, discounts given to HMOs and Blue Cross, as well as the cost of bad debt and providing free care by shifting the costs to the commercial insurers and self-payers. Examples of commercial insurers are the John Hancock, Aetna, and the Travelers insurance companies. A self-payer is an individual without health insurance or a self-insured employer.

**Health Maintenance Organizations (HMOs)**

HMOs have proliferated in Massachusetts over the last decade. Massachusetts ranks second in the country in terms of enrollment. Generally, four types of HMO plans exist in Massachusetts: Group, Staff, Independent Practitioner Association (IPA), and Network. According to a 1990 issue of *Managed Care Outlook*, about 50% of enrollees in Massachusetts choose the IPA type of HMO. The IPA type of HMO allows members to choose their own physician as long as the physician is a member of the IPA.

**SYSTEMS OF HOSPITAL CARE FINANCING**

Before 1982, hospital care was financed by a fragmented body of passive insurers and payers that paid claims without asking hard questions of the providers. It was a shell game of shifting costs. What continues to exist is a fragmented health insurance market that rewards good risk and penalizes bad risk.

Cost-based reimbursement was the system of choice for most payers and insurers prior to October 1, 1982. That method of reimbursing hospitals seemed to invite them to expand. Under cost-based reimbursement, hospitals assumed that whatever it cost to treat patients would be paid for by somebody. It was a payment system that created almost unlimited access to health care services for insured patients. Unfortunately, it was bankrupting the health care system.

David M. Kinzer, late president of the Massachusetts Hospital Association, described the state of hospital care financing in Massachusetts at that time (1982):

"Hospital care financing is now a patchwork of conflicting policies, with different payors using different definitions of allowable costs, and with the charge payor or the insurance companies that pay on the basis of charges picking up the slack on what the
cost payors refuse to acknowledge as a responsibility...
Charge schedules have been set up to pick up what the
government has not covered... The inequities of the
situation have been compounded by the “free care and
bad debt” experience of our Massachusetts hospitals,
the costs of caring for people with no money and no
coverage or who just don’t pay their bills. 20

Clearly, something had to be done and the General Court
responded. On August 10, 1982, then Governor Edward J. King signed
into law Chapter 372 of the Acts of 1982. Effective October 1, 1982,
this hospital cost containment law created an all-payer hospital care
payment system that was to restrain out of control hospital costs.

Chapter 372

Led by the powerful business coalition known as the Massachu­
setts Business Roundtable, the primary impetus for the Chapter 372
legislative reform came from the business community. Joining them
as well were the commercial insurers and the Rate Setting Commis­
ion. This was a dramatic and decisive turnaround. As hospital costs
soared during the 70s, the business community and commercial
insurers remained relatively silent and had little influence over how
or how much hospitals and other health care providers were paid.

However, at the dawn of the 80s, representatives of business argued
that health care costs were increasing at intolerable rates. They warned
that if action was not taken to reduce costs, many businesses would
leave or, at a minimum, not expand in Massachusetts. Cost-shifting
by hospitals had been identified as a major cause of increasing health
care costs for business. A solution had to be found that would reduce
cost-shifting by hospitals.

In mid-1982, after months of acrimonious debate, many threats,
and much political maneuvering, an agreement was reached between
hospitals, insurers, and members of the business community for an
all-payer financing reform bill. At the time, there were only three other
states (Maryland, New York, and New Jersey) with all-payer payment
systems.

Chapter 372 contained the following tenets:

20 David M. Kinzer, late President, Massachusetts Hospital Association, Hospital Concerns with Senator
Daniel Foley’s Redrafted Legislation to Prevent “Cost Shifting” by Hospitals onto Private Payors, Press
• It created an all-payer financing system that eliminated incentives for hospitals to shift costs from one payer or insurer to another.

• It reflected a three-year waiver from the regular Medicare payment system that authorized Medicare participation in the all-payer reimbursement system. The waiver precluded participation by Massachusetts hospitals in the Diagnosis Related Group (DRG) prospective payment system.

• It set aside money to assist hospitals which served a disproportionate number of the poor, the indigent, or people otherwise financially at risk.

• It set limits prospectively on hospital revenues.

• It allowed hospitals to increase budgets on the basis of the incremental cost of care.

• Uncompensated care (free care and bad debt) provided by hospitals was recognized by the private sector payers and insurers as a cost for which they were responsible. The cost of uncompensated care was built into hospital rates and all-payers paid proportionately.

• It established incentives to provide outpatient rather than inpatient care

According to the Boston University School of Public Health Access and Affordability Monitoring Project (AAMP), Chapter 372 intended to ratchet back high hospital payments by applying a productivity squeeze to all hospitals. In other words, hospitals had to become more efficient to be financially viable. Each hospital was to be squeezed equally using its base year 1981 costs. This, unfortunately, penalized hospitals which were efficient in 1981, and gave an unfair advantage to hospitals which were not efficient in 1981.

Nevertheless, the Chapter 372 all-payer system succeeded in reducing the rate at which hospital costs were increasing. Although the decrease was modest, the upward trend slowed. From being 40.4% above the national per capita average in hospital spending in 1980, Massachusetts dropped to 34.5% above in 1987.21 Indeed, between

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21 Sager, Socolar, and Hiam, *Summary, Analysis, and Recommendations on The WELD ADMINISTRATION'S COMPETITIVE HOSPITAL PAYMENT PLAN*, Boston University School of Public Health Access and Affordability Monitoring Project, 16 September 1992, p.7 (Note: These data are under revision to reflect new census figures).
1980 and 1985, free market approaches to hospital cost containment were less successful than the results obtained in states with highly regulated all-payer rates setting systems. When the California market approach is compared to the all-payer rate setting systems in Massachusetts, Maryland, New York and New Jersey for the 1982-86 period, hospital costs per admission were lower by 16.3% in Massachusetts, by 15.4% in Maryland, by 6.3% in New York, and by 1.9% in New Jersey.\textsuperscript{22}

\textit{Chapter 574}

In December of 1985, the hospital financing law was again changed by the enactment of Chapter 574 of the Acts of 1985. These adjustments were necessary because the three-year waiver from the Medicare Diagnosis Related Group (DRG) prospective payment system expired. Massachusetts hospitals could have applied for an extension of the waiver, but did not because of the presumed financial benefit of participating in the national DRG system. This abandonment of the Medicare waiver fractured the carefully cultivated all-payer system undergirding Chapter 372. New legislation was necessary to control the pricing changes which hospitals might have made to offset the unknown financial risk of joining the DRG system. The reform:

- Created a method of funding free care and bad debt (uncompensated care) through the hospital payment structure. Hospitals would be reimbursed for uncompensated care by way of a surcharge to private sector payers. Uncompensated care costs were combined among all hospitals to eliminate competitive disincentives.
- Established an Advocacy Office at the Department of Public Health to act on complaints from Massachusetts residents on Medicare.
- Prohibited hospitals from discriminating against Medicare patients.
- Restricted the cost increases that hospitals could pass on

\textsuperscript{22} Dr. Gerard F. Anderson, \textit{All Payor Rate Setting: Down But Not Out}, a paper presented at the Massachusetts Health and Educational Facilities Authority Health Policy Forum, 20 September 1991, p.13.
to other payers subsequent to Medicare's non-participation in the all-payer system.

- Continued a cap on allowed hospital revenues

Chapter 574, like its immediate predecessor, was successful in restraining health care costs. Massachusetts hospital costs per capita rose only about two-thirds as fast as they did for the nation as a whole.\(^{23}\)

**Chapter 23 (Health Security Act)**

On April 21, 1988 the third major hospital care financing legislation of the 1980s was enacted. Chapter 23, a health care financing and universal access law, was nourished in the womb of presidential politics. It received nationwide attention during the 1988 presidential campaign. Chapter 23 contained two major components: (1) it called for universal access to health care services for all Massachusetts residents by 1992; and (2) it continued the prospective and capped hospital rate reimbursement system.\(^{24}\)

**Financing**

Although the law received more publicity for its promise to provide health care coverage for the state’s uninsured, Chapter 23 provided hospitals with financial incentives to expand inpatient and outpatient volume. This ultimately reversed the downward trend of the rate at which hospital costs were increasing and increased overall hospital costs.

Alan Sager, Deborah Socolar, and Peter Hiam from the Boston University School of Public Health Access and Affordability Monitoring Project estimated that Chapter 23 was responsible for $3 billion in additional hospital costs because of changes that allowed hospitals to adjust charges for inflation and gave them competitive incentives to expand volume, including outpatient usage.\(^{25}\) The evidence they produced was compelling. In 1989, outpatient visits increased by 9.9% or 700,000 visits. Inpatient admissions increased

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\(^{24}\) Excerpted from a report to the Governor and the General Court by the Special Commission on Health Care Finance and Delivery Reform, December 1990.

\(^{25}\) Testimony before the Joint Committee on Health Care of the Massachusetts State Legislature, July 1991.
for the first time in six years. Contrary to the national trend toward lower admissions, between 1987 and 1989, Massachusetts per capita health care costs rose more than any other state, primarily because of regulations that rewarded increased hospital volume. They also noted that these increases occurred in spite of the state's rise from fourth to second among the states in HMO enrollment.

Access

Presidential politics aside, the need for a serious response to the important issue of hospital care access was apparent. Chapter 23 created the Department of Medical Security (DMS) to manage the implementation of the Health Security Act of 1988. According to information provided to the Committee by the Department of Medical Security, the Health Security Act had two principal goals:

(1) phase-in over four years (1988-92) a public-private system of universal access to affordable health insurance.

(2) create a hospital reimbursement system which ensured swift and adequate payment to hospitals.

Massachusetts is one of fifteen states that account for 70% of the nation's uninsured. The percent of the population uninsured in Massachusetts increased from 9.9% (506,000) in 1988 to 11.1% (559,000) in 1990. It is important to realize that most of the uninsured are not unemployed. Many work part-time or for employers who do not offer health insurance to part-time employees. Eighty-four percent of the uninsured are employees or dependents of employees.

Department of Medical Security Initiatives

Because of fiscal constraints, the role of the Department of Medical Security (DMS) has been altered. The "major mandate" of Chapter 23, a requirement that businesses with over six employees provide health insurance to employees or contribute into a special state fund, has been delayed until 1995. DMS provided the Committee

26 Ibid.
28 Employee Benefit Research Institute, Number of Uninsured Americans Increases to 35.7 million, Press Release, January 23, 1992.
29 Massachusetts Department of Medical Security, Transition Report, November 1990, p. 2.
with the following summary of the Department's current responsibilities:

(1) Hospital Free Care Pool — This pool pays hospitals for the free care provided to low income persons without health insurance. It is funded by a 9% assessment on health insurance bills. The amount collected is now capped at $300 million.

(2) Health Security Plan — This plan provides temporary health insurance to people receiving unemployment compensation and their families. The plan is administered by the John Hancock Mutual Life Insurance Company. As of March 1992, a total of 13,708 people were enrolled in the Health Security Plan.

(3) Student Health Insurance — Since 1988, full-time college students attending schools in Massachusetts must either document that they have health insurance or purchase it through the institution they are attending.

DMS also collaborates with the Massachusetts Hospital Association to train health care workers and, through a program called CenterCare, DMS works with community health centers to offer health care services to low income individuals. Also, under the new Chapter 495 hospital payment law, DMS will be administering a $5 million preventive pediatric health care services program.

Chapters 372, 574, and 23 were cut from the same mold. They were well-intentioned efforts by legislators, hospitals, employers, business coalitions, and insurers, to divide up the multi-billion dollar health care pie into acceptable slices. Unfortunately, no consensus has yet been fashioned to agreeably apportion the pie.

The evidence suggests that the rate at which health care costs were increasing was beginning to decrease during the tenure of the Chapter 372 and 574 systems. Central to these promising signs of success was the attempt to cap revenues. Although not perfect, under their watch, certain indicators that forecast increasing health care costs began to decline. The subsequent increased hospital revenues allowed by Chapter 23 countered any earlier progress made in this regard. So after a decade of diligent effort, Massachusetts continues to struggle with increasing health care costs. This state of affairs guaranteed that the successor to Chapter 23 would attempt to radically restructure the hospital care financing environment.
SECTION THREE:
COMPETITION AND THE HEALTH CARE MARKET

On July 3, 1991, Governor F. William Weld filed "An Act to Reform the Acute Care Hospital Payment System in Massachusetts." This legislation was intended to replace Chapter 23, the existing hospital reimbursement law. Chapter 23, slated to expire in September of 1991, was extended until a new hospital reimbursement law could be enacted.

Chapter 495, the eventual successor to Chapter 23, was signed into law on December 31, 1991. It embraced competition as a valid method to reduce the rate at which hospital costs were increasing in Massachusetts.

The primary tenets of Chapter 495 include the following:

- deregulating hospital prices and revenues
- allowing unrestricted contracting between hospitals and payers
- establishing small business health insurance reform

Health Care Competition

Much of the hospital reimbursement reform legislation brought before the legislature for consideration as a successor to Chapter 23 promoted hospital price competition through selective contracting to reduce the rate at which hospital costs were rising. Proponents of hospital competition contend that it will cause prices to drop and hospitals will be forced to become more efficient. Opponents feel that traditional free market competition will favor large purchasers of care and will increase the number of uninsured. Proponents and opponents agree that deregulating hospital pricing symbolizes more than just a change in how to pay for hospital care. Many observers concede that it marks a new ideological change from government regulation to government promoting an entrepreneurial health care system.

Chapter 495 and similar laws which emphasize competition for patients among hospitals, usually encourage claims payers to selectively contract with hospitals. But hospitals contracting with payers is controversial, because it is viewed by some as a process that favors bulk buyers of hospital care possibly to the detriment of small buyers of hospital care. Competition may enable the state, and other large purchasers of hospital care services, to leverage their position
in the market to obtain advantageous prices. It encourages large employers and insurers to be knowledgeable buyers rather than just payers of claims.

The Commonwealth of Massachusetts, with approximately 250,000 members in its health plans, is a good example of how large purchasers of care are winners under competitive financing. Massachusetts can exercise enormous market power. According to fiscal year 1990 utilization reports provided by the Group Insurance Commission, $82 million was spent by the Commonwealth for hospital care just for employees enrolled in the State Hancock Plan. Forty-six percent of this money was paid to only twenty teaching hospitals. Ten psychiatric hospitals received another 10% of the State Hancock Plan dollars. Assuming that it can negotiate beneficial contracts, the Group Insurance Commission should be able to reduce the rate of increase in state employee health care costs. Despite the savings that competition is supposed to achieve for power buyers such as the Commonwealth of Massachusetts, the administration is proposing that state employees contribute 35% of the health insurance premium: an increase of 250% from the present contribution level.

Another clear winner in the anticipated competitive battle will be Blue Cross, if for no other reason than size. With over two million subscribers, it is hard to imagine Blue Cross not being able to wield tremendous market power over the state's hospitals.

While it is yet unclear how wide-scale contracting will affect the cost and quality of care for the market as a whole, the question already being asked is: Should public policy allow cost-shifting by hospitals to small businesses and employees by allowing market power to be exercised by large businesses and insurers? The question is important and requires an early response. It is likely that competition may initially drive down the price of care for large buyers, but there is no guarantee that the underlying costs will be equally reduced. In that event, there is a strong possibility that selective contracting may drive up prices for the purchasers of hospital care with no market power. The probable result will be that those who cannot exert price pressure will be forced to pay more. In a free competitive market, all buyers are supposed to pay relatively the same price, but that may not occur in this market.

30 Massachusetts Senate Committee on Post Audit and Oversight, Controlling State Employee Health Care Costs (Senate Bill No. 1610), June 1991, p. 39.

If hospitals, as they have in the past, make up for the discounts they will be giving to large self-paying businesses, insurance companies, and HMOs by charging other payers higher prices, there could be serious consequences felt in the rest of the market. Uncontrolled price concessions to power buyers could cause premiums to skyrocket for small businesses and self-paying individuals. This could force some small businesses to pay higher premiums or copayments, offer stripped-down coverage, or to eliminate medical coverage totally, thus restricting access to care and increasing the number of underinsured and uninsured. Ultimately, the cost of the lack of access and increasing levels of free care and bad debt will have to be absorbed by all of the remaining purchasers, just as it is in the other free markets. Consequently, it is difficult to discern how the Massachusetts health care system will show overall cost improvement if discounts are given to some at the expense of others.

Questions abound about what will happen to the quality of hospital care in the race to force price concessions from hospitals. Proponents readily concede that in order to successfully negotiate truly beneficial contracts with hospitals, payers must possess substantial technical expertise in a number of areas outside of financial considerations. They acknowledge that insurers and large self-paying businesses have a responsibility to their insured or employees to obtain care that is not only reasonably priced, but is also of good quality. At a minimum, negotiators will have to be adept at analyzing cost and charge data, quality based data such as morbidity and mortality rates, and hospital-wide and departmental quality assurance studies. While of all of this is recognized or conceded, little has been done to insure that quality of care will not be subordinated to the bottom line needs of price shoppers.

**Will Competition Work?**

Competition among providers of health care services has increased dramatically over the last decade. All hospitals want to attract their market share, and a strong argument can be made that hospitals have been competing among themselves for quite some time. The use of advertising by hospitals and physicians, discouraged in the past by medical ethics, now is as common as receiving a flyer from the local grocery store. Who hasn't received a marketing brochure from a local hospital or a local physician notifying them of some sort of free clinic
or service? Even small community hospitals have strategic marketing plans, and regularly use print and media advertising campaigns.

Of course, just because price competition among hospitals has been approved does not mean they will price compete. Just as in any market, especially in a sellers' market, a seller can differentiate itself from the market and compete on factors other than price. An example of this form of non-price competition would be a hospital that positions itself in the market by virtue of a special service or technology it offers. Hospitals service compete with other hospitals, drive-in emergency rooms, clinics in shopping malls, and even with their own staff physicians, some of whom have been known to group together and offer, at their offices, services that could be provided by the same hospital where they admit their patients. Although this type of competition was originally driven by pressure put on hospitals by insurers and other payers to lower costs by providing services to patients at sites less costly than hospitals, service competition also can increase hospital costs by forcing some hospitals to invest in technology and services that will be attractive to potential contractors.

The utilization of magnetic resonance imaging (MRI) machines is an example of how hospitals service compete for market share by purchasing the latest medical technology. A 1987 article on health care costs in the Boston Globe details how a certificate of need for a MRI was awarded to a for-profit health care group that had formed an alliance with a Boston teaching hospital to interpret MRIs. The group’s primary competition for the certificate of need came from a hospital that was supported by 18 other hospitals. This was not only competition between a hospital and a for-profit health care group, but was competition between a community hospital and a Boston teaching hospital that was attempting to extend its market share to the community setting.

Boston’s world famous teaching hospitals have built reputations, not only because of their excellent care, but also because they have full time, highly paid marketing and public relations personnel who won’t let the public forget their hospitals’ well-deserved reputations. These efforts seem to have been more than successful. The reputations of many of our teaching hospitals have led to high occupancy rates. This is noteworthy, because hospitals with higher than average

occupancy rates have less of a need to compete.\textsuperscript{33} The higher occupancy rates in Massachusetts hospitals, especially teaching hospitals, is reflective of the beneficial reputation of hospital care delivery in Massachusetts. If higher occupancy rates are indicative of market power, that market power may be manifested in higher prices at many Massachusetts hospitals, provided that the hospital market behaves like a normal economic market.\textsuperscript{34} In other words, because of the relatively high occupancy rates of Massachusetts hospitals, it is reasonable to assume that many will have no reason at all to price compete.

Hospitals also \textit{price compete} for insurance business, most notably for HMO business. Chapter 372 allowed hospitals to discount prices for HMOs. It was anticipated that hospitals which contracted with HMOs would be more efficient and less costly because they had given discounts to HMOs. However, some hospitals may have contracted with an HMO to provide care for a discounted price, but simply cost-shifted to other hospital claims payers to make up for HMO costs not covered by the HMO payments. It is interesting to note that Massachusetts health care costs continue to soar in spite of an HMO enrollment that is second only to California. It is likely that this is occurring because although HMOs have been successful in significantly reducing the hospitalization rates through strict inpatient care management, outpatient care utilization has increased. So, while HMOs and other innovative methods of managing care may reduce hospital costs, total health care spending has not decelerated.\textsuperscript{35}

Much discussion has occurred about whether free market competition can work in the health care market. An article in the Boston Globe on health care competition in Massachusetts, described the four major reasons some local health care economists feel competition does not work in the health care market.

\begin{itemize}
  \item The rules of the free market do not apply to health care because it involves more than just buyers and sellers. The real health care market is doctors, hospitals, insurers, and government. It is doctors who decide what services are needed, not the patient. It is insurers and other claims payers
\end{itemize}


\textsuperscript{34} Ibid., pgs. 36-37.

who have little control or knowledge about the appropriateness or necessity of what they are paying for. It is governments that struggle to pay for as much care as possible with limited revenue. It is hospitals that save lives and get blamed for increasing costs. And it is free care and bad debt that everybody must pay for.

- Health care competition only has winners and losers. It is big payers who negotiate good deals and small payers who will make up the difference. It is bulk buying versus individual buying.

- Health care competition does not get at the real causes of medical inflation: duplication of medical technology, rising labor costs, and an aging population. Price competition could also affect quality of care if hospitals are forced to become overly efficient.

- The wrong conditions are in place for competition to be successful. Massachusetts residents are used to the freedom of choosing their own physicians and hospitals. Health care competition will affect freedom of choice. Health care competition presumes most hospitals will compete or close. Our most expensive teaching hospitals don't need more patients. Occupancy rates are higher than the statewide average. Other than eliminating competitors (low cost hospitals), why would hospitals with high occupancy rates want to compete?36

Recently, the Access and Affordability Monitoring Project (AAMP) of the Boston University School of Public Health did extensive research on the probable effects of a competitive health care environment in Massachusetts. The research showed that competition is likely to be beneficial to payers with many clients or hospitals with high occupancy rates. The project concurred with advocates of competition who claim that hospitals would close, further restricting access to care. The project also emphasized that the four fundamental requirements for a free market are absent in this state. Those prerequisites are (1) Each buyer or seller must be relatively small and unable to influence price; (2) Supply, demand and price must face

no artificial restraints; (3) Sellers must be able to enter and leave the market freely; and (4) Buyers and sellers need good price information.

AAMP also published two papers that examined the effects of competition in two other states: Minnesota and California. One detailed paper, entitled "Manipulating the Minnesota Marketplace," describes how hospitals, HMOs, doctors and insurers attempted to boost their bargaining power rather than improve their efficiency. Huge discounts for HMOs caused hospitals to react by forming hospital systems to force the HMOs to negotiate with the "system" if they wanted to provide access for all enrollees.

Another paper published by AAMP, entitled "California's Catastrophic Competition," noted that overall health care spending in California (2nd nationally to Massachusetts) would be higher if it did not have one of the nation's highest proportion of uninsured. Massachusetts has one of the lowest uninsured populations. A 1991 California Policy Seminar report published by the University of California indicates that 5.9 million Californians (22.5% of the population under 65 and 33% higher than the national average) were uninsured in 1990. In Massachusetts just over 11% of the population under 65 was uninsured in 1989. A fear exists that competition in Massachusetts will increase the number of uninsured as it may have when competition was introduced in California. Although little direct evidence exists that suggests that selective contracting increased the number of uninsured in California, the way insurance plans responded (increases in medical underwriting, red lining, selective marketing, and dumping small businesses) to competition may have increased the number of uninsured. 37

Finally, an April 1991 Congressional Budget Office (CBO) study entitled "Rising Health Care Costs: Causes, Implications, and Strategies" states the following: "Changes in the competitive nature of the market for health care services would suggest that, if competition were an effective strategy, the rate of increase in health care costs in the United States would have declined during the 1980s, particularly in areas that have been highly competitive."

Although the number of studies on the impact of competition is limited, the findings of the CBO study suggest that:

• The effect on hospital costs is uncertain, with some studies suggesting competition lowers costs and others indicating costs are unaffected or higher in more competitive markets;

• Competition can lead to product differentiation and higher costs, rather than price competition and greater efficiency; and

• A higher HMO market share may not be associated with lower hospital expenses per-capita in a market area, even if per-capita hospital expenses for HMO members are lower, apparently because of offsetting increases in hospital expenses for patients not enrolled in HMOs.

SECTION FOUR: CONCLUSIONS AND RECOMMENDATIONS

On December 31, 1991 Governor Weld signed into law Chapter 495, an enactment entitled: “An Act Improving Health Care Access and Financing.” This hospital care financing law deregulates hospital prices and revenue and hopes to intensify competition in the market. Clearly, competition will require that hospital care be viewed in terms of economic policy rather than in terms of social policy. In other words, to survive in their respective markets, sellers and buyers of care will have to focus on maximizing profits and reducing health insurance payments, rather than focusing on providing quality health care for all.

The likelihood that access and quality of care may be threatened by competition is distressing. The research performed for this report has produced information that requires the Committee to conclude that competition, in the long term, is not likely to succeed in reducing health care costs in Massachusetts. The Committee forecasts that under the tenure of Chapter 495 the following will doubtless occur:

• Efforts to reduce health care costs will continue to overshadow efforts to provide quality care.

• Hospital costs will decline for some hospitals in the near term. This will occur because of the competitive price cutting that will initially be demanded of hospitals by large purchasers of care and because of the general slowdown in the Massachusetts economy.
• In the long term, overall health care costs will increase even though hospital costs will show some decline. Price competition will put pressure on hospitals to provide care on an outpatient rather than on an inpatient basis. However, the increased cost of providing outpatient care will override decreases in the in the cost of providing inpatient care.

• Underinsured or uninsured people in Massachusetts will have less access to hospital care due to competition. Hospitals will not be able to provide as much care for the uninsured or underinsured because they will be providing discounts to many large purchasers of hospital care.

• Price competition will cause some hospitals to merge into “care systems” which, because of their resulting combined market strength, will not have an incentive to give discounts to purchasers of care.

• Health insurance coverage for small businesses in Massachusetts will continue to be expensive because small purchasers of care will have to subsidize the discounts given to large purchasers of care. Ultimately, the increasing cost of health insurance for small businesses will force more of them to eliminate this coverage and further increase the number of uninsured residents in Massachusetts.

Moreover, because Chapter 495 articulates a public policy that allows the exercise of market power by large payers at the expense of small payers, the Committee fears that Massachusetts will spawn a system of health care that provides comprehensive health care benefits only to those with wealth or market power. This preference for power buyers of health care could also prove counterproductive outside the health care system. Creating a health policy that may negatively affect small businesses, the very sector of the state economy responsible for most job growth, seems the wrong way to lead Massachusetts out of its current recession.

When the fact that $8 billion is already being spent in Massachusetts for hospital care, an amount some experts believe should be enough to provide hospital care for all Massachusetts residents, is coupled to the administration’s own firm conviction that the previously restrained market has produced substantial inefficiencies and overcharges, this Committee believes it has a reasonable basis to
conclude that revenue limits on individual hospitals, as well as the overall hospital system, could have accompanied the introduction of the competitive model for Massachusetts hospitals. Further, the Committee believes this could have been done without interfering with this admittedly experimental approach to hospital care financing.

Additional attention should also be directed to the fact that the non-government parties in the newly created competitive hospital care financing market — health maintenance or preferred provider organizations, insurance companies, and hospitals — have, in many facets of their business activities, operated their affairs with little concern for the applicability of both Chapters 93 and 93A of the General Laws, the statutory scheme governing business behavior in traditional competitive markets. The Committee is concerned that many participants in this newly emancipated marketplace may not realize that, while joint efforts to persuade a regulatory body to establish a price or rate may be insulated from challenge from anti-trust law, similar conduct cannot be used to establish prices in the unregulated market.

The Committee is particularly concerned by the absence of any evaluative or oversight provisions in the present legislation governing hospital finance. No attempt has been made to establish criteria that will help future legislatures determine whether the experiment is working or whether consumer protection or anti-trust violations have occurred. The failure to indicate what constitutes success or the acceptable trade-offs for its accomplishment almost guarantees future legislative battles.

To remedy these oversights, the Committee offers the following recommendations regarding Chapter 495 legislation:

- The consumer protection unit of the Attorney General's Office should make resources available to monitor consumer protection or anti-trust violations which may occur as a consequence of deregulating hospital pricing.

The Committee's concern about the application of the anti-trust laws to hospital care financing is heightened by its belief that many aspects of the health care industry may not be susceptible to the discipline of a truly competitive market. For this reason, the Committee believes that it could be beneficial to all if the Attorney General used the broad rule making powers granted under 93A to provide guidance
for the industry as it reacts to its new freedom. Such guidance could help insure that marketplace participants are playing on a level playing field.

- Chapter 195 should be amended to include a "fail-safe" system-wide revenue cap. Chapter 495 should require that if hospital revenues grow beyond predetermined levels, the law be immediately suspended and reviewed.

The Committee feels that at some point a decision has to be made regarding the success or failure of Chapter 495 in terms of system-wide hospital revenue growth. No provision of Chapter 495 requires that the law be suspended if hospital revenues continue to grow unchecked under competition. After all, Chapter 495 did not legislate away any of the systemic reasons hospital and insurance costs are high, such as teaching hospitals, and expensive methods of treating sickness and disease.

- Chapter 495 should be amended to include a two year sunset provision. Two years after the implementation of Chapter 495, the Rate Setting Commission should determine the effects of hospital price competition.

The sunset review should not be viewed as a threat to Chapter 495 or the concept of health care marketplace competition. Rather, it should be viewed as an effective, productive and responsive method of legislative evaluation. Two years of hospital care financing experience under the aegis of Chapter 495 should be enough time to determine whether price competition is a viable method of restraining health care costs in Massachusetts.

Because Chapter 495 is an experiment and may threaten access to affordable hospital care for many of the state's residents, the Committee is recommending that Chapter 495 undergo an independent sunset review in two years to determine the success or failure of restraining health care costs through competition. This review should be conducted by the Rate Setting Commission and the legislature should appropriate resources which the Rate Setting Commission can use to obtain health economists, lawyers, statisticians, accountants, and others who will develop a model to measure the effects of competition on the health care market.
The Committee believes the overriding goal of hospital care financing reform in Massachusetts should be to provide access to health insurance coverage for all residents of the state. This access should be provided without creating financial incentives that increase costs and limit access to affordable quality care.

While the Chapter 495 experiment is being tested, the administration should be planning an alternative to this approach, should the free market competitive model fail. Absent firm and decisive national leadership on the issue of health insurance coverage for all citizens, Massachusetts should renew its effort to provide universal health coverage for all residents.

Three central universal health plan models exist. The Canadian national system, the all-payer "pay or play" system, and a system that provides tax credits to business for providing health insurance for employees. Many variations of these systems have been discussed. The Committee recognizes that these health plans have merits and flaws and is not recommending that the commonwealth adopt any of the plans at this time. As Chapter 495 may or may not restrain hospital cost growth, alternatives should be continually developed. Even if it has some positive effect on reducing hospital revenue growth in the short term, Chapter 495 will not restrain overall health care costs or guarantee access to hospital care for all of the commonwealth's residents. During the term of Chapter 495, access to affordable health care for all of the commonwealth's residents should be part of an ongoing study.